Date Rec'd:_____
Rev: 081011

CITY OF CHICOPEE, MASSACHUSETTS
First Report of Accident or Injury

This form must be completed IMMEDIATELY after an accident or injury, by the employee, and submitted to Human Resources (594-1513 FAX), unless the employee is incapacitated or unavailable due to emergency medical treatment. A copy must also be provided to the supervisor of the employee.

YOU MUST ALERT YOUR SUPERVISOR IMMEDIATELY AFTER AN ACCIDENT.

1. EMPLOYEE

Name: Department:

Phone Number: Supervisor:

2. ACCIDENT CIRCUMSTANCES

Time/Date of Accident:

Location:

Witnesses:

3. INJURY/ACCIDENT

What was injured:

What was the cause of injury:

Other Comments:

_____ _____
Employee Name Employee Signature